**Therapist**_____

**Diagnosis:**_____

**Karen Mahan, LCSW**
**Transitions Equine LLC**
**Mukwonago, WI 53149**
**Mukwonago___ Elm Grove___**

**CLIENT INFORMATION** *Confidential*

Date:_____ Referral Source: _____

Client Name:_____
Last First Middle initial

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email address:_____ Marital Status:____ Sex:___

DOB:_____ Age:_____ Social Security No.:_____

Employer Name/Address:_____

Emergency Contact:_____ Phone:_____

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Person Financially Responsible:_____ Birth Date:_____

Relationship to Client:_____ Employer_____

Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

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**Please Provide Insurance Card(s)**_____

Dependent Children:

Name Birth Date Name Birth Date_____

_____

_____

_____

Primary Care Physician's Name:_____ Phone: _____

Address:_____State_____ Zip_____

# Patient Assignment of Insurance Benefits and Authorization to Release Information

I acknowledge that I have received a copy of the patient bill of rights and the informed consent for treatment form. I hereby agree to treatment and understand that if I have questions, I will contact my therapist ..

I hereby authorize any insurance carrier to make payment directly to Karen Mahan, LCSW of any benefits otherwise payable to me for services provided by Karen Mahan, LCSW or Transitions Equine LLC staff. I understand that I am financially responsible for all charges whether or not paid by my insurance company (s).

I authorize Karen Mahan, LCSW to release to my insurance company(s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment procedure and/or photocopies of all or part of my record.

Confidentiality will be strictly maintained under the guidelines of professional ethics and the procedures defined by my insurance program.

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Patient Guardian Signature

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Therapist Signature

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Date

**Karen A. Mahan, LCSW**
**dba Transitions Equine LLC**

_____
NAME

# Health History Questionnaire

1. Please list all current medications you are taking for either physical or emotional difficulties:

_____

_____

2. Allergy (Medications): _____
3. Current Medical/Emotional Conditions (please check):

| | | |
|---|---|---|
| ___Anxiety | ___ Diabetes | ___Sleep Disturbance |
| ___Allergies | ___Epilepsy/Seizure Disorder | ___Stomach Problems |
| ___Asthma | ___Frequent Constipation | ___Skin Problems |
| ___Arthritis | ___Frequent Headaches | ___Sexually Transmitted Disease |
| ___Back Trouble | ___Fatigue | ___Vision Problems |
| ___High Blood Pressure | ___Hay Fever | ___Weight Loss/Gain |
| ___Cancer | ___Heart Problems | ___Smoker/Amount per day___ |
| ___Depression | ___Irritable Bowels | ___Other_____ |

Is there any family history of the above conditions?_____

4. Medical Doctor_____Last Physical Exam_____

Currently being treated?_____Problem:_____Date Last Seen:_____

5. Have you ever previously been seen for outpatient therapy? (list previous therapists/reasons)

_____

_____

Have you been previously hospitalized for emotional difficulties? (list previous hospitals/dates)

_____

Have you previously been treated for chemical dependency? (List hospitals/dates)

_____

6. Do any family members have chemical dependency, alcoholism or emotional problems? List:_____

7. Do you use sedatives, alcohol, tobacco, laxative, caffeine? Type and amount per day:. List:_____

8. Are you having problems in your sexual relationship? _____

**Karen Mahan, LCSW dba Transitions Equine LLC**
**Informed Consent for Treatment**

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of my practice regarding confidentiality of your health information. Your rights as a patient are shown below.

A. The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs: improved communications skills, clearer thought process, and more stable mood.
B. Services provided may include psychiatric assessment, case management., group, individual, family and couples therapy. If medication is part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.
C. The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experience with your treatment providers. Certain medications may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluations. It is your right, unless under court order, to decide whether or not you want to take any medication.
D. If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.
E. The treatment staff may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.
F. You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.
G. Services never involve sexual contact between therapist and client; this is unethical and against the law.
H. The is informed consent will be in effect no longer than fifteen months from the time that consent is given.
I. You have a right to withdraw this informed consent, in writing, at any time.

**Denial of Patient Rights**

Your rights may only be denied in certain circumstances such as:

1) When there is a danger to life or health of the client or potential harm to others.
2) Suspected cases of child abuse or neglect (s.48.98)
3) A lawful order of the court to which you must comply.

By by signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment. ;My signature below also confirms this information provided to you:

Client Guardian Signature Date

Client's Name (print ) Date of Birth

Witness Date

*If client doesn't sign, please document reason:

**Karen Mahan, LCSW DBA Transitions Equine LLC**
**Client Intake Form**

Last Name:_____ First Name:_____

Date of Birth:_____ Date of Assessment:_____

Circle the number that best describes problems you have in the following areas. If not applicable, leave blank:

**3=Severe 2=Moderate 1=Minimal**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Depression | 3 2 1 | Financial Problems | 3 2 1 | Excessive Spending | 3 2 1 |
| Anger | 3 2 1 | Sexual Problems | 3 2 1 | Grief Issues | 3 2 1 |
| Anxiety | 3 2 1 | Sexual Orientation Issues | 3 2 1 | Marital | 3 2 1 |
| Withdrawn | 3 2 1 | Alcohol/Drug Use (self) | 3 2 1 | Other Relationships | 3 2 1 |
| Suicidal Thoughts | 3 2 1 | Alcohol/Drug Use (others) | 3 2 1 | Parenting Problems | 3 2 1 |
| Suicidal Attempts | 3 2 1 | Gambling | 3 2 1 | Physical Abuse | 3 2 1 |
| Job Problems | 3 2 1 | Excessive Eating | 3 2 1 | Sexual Abuse | 3 2 1 |
| Legal Problems | 3 2 1 | Excessive Dieting | 3 2 1 | Domestic Violence | 3 2 1 |

How long has problem existed? ____weeks ____months ____years

In the past six months, have you experienced the following? (Please check all that apply)

Physical Reactions:

| | | | |
|---|---|---|---|
| ____Rapid Heart Rate | ____Dizziness | ____Lightheaded | ____Headaches |
| ____Stomach Aches | ____Nausea | ____Chest pain/Pressure | ____Sweating |
| ____Shaking | ____Impaired Sleep | ____Fatigue | ____Muscle Tension |
| ____Neck or Back Pain | ____Other_____ | | |

Mental Reactions:

| | | | |
|---|---|---|---|
| ____Nightmares | ____Flashbacks | ____Intrusive Images | ____Homicidal Plans |
| ____Suicidal Thoughts | ____Suicidal Plans | ____Homicidal Thoughts | ____ Obsessive thoughts |
| ____Paranoia | ____Delusions | ____Hallucinations | |
| ____Compulsive Behavior | ____Phobias | ____Short-term memory | ____Long-term memory |

Other:_____

Emotional Reactions:

| | | | |
|---|---|---|---|
| ____Fears | ____Feeling Unsafe | ____Sadness | ____Grief |
| ____Mood Swings | ____Anxiety | ____Depression | ____Anger |
| ____Irritability | ____Fatigue | ____Guilt | ____Shame |
| ____Blaming(self/others) | ____Difficulty trusting others | ____Emotional Numbness | ____Sensitive |
| ____Isolating | ____Poor Memory | ____Poor concentration | ____Worthlessness |
| ____Lack of Sexual Desire | ____Crying Spells | ____Hopelessness | ____Lack of Motivation |

Other_____

Behavioral Reactions:

| | | | |
|---|---|---|---|
| ____Suicide Attempts | ____Agitation | ____Loss of Interests | ____Easily Distracted |
| ____Confrontational | ____Aggressiveness | ____Withdrawn | ____Procrastination |
| ____Easily Startled | ____Overeating | ____Under eating | ____Anorexia |
| ____Binging | ____Purging | ____Bulimia | ____Gambling |
| ____Increased alcohol use | ____Alcohol Dependence | | |
| ____Sexually Inactive | ____Sexually Overactive | ____Other Substance Use | |

Other_____

Do you physically harm yourself? How so?_____
_____
_____

What are your current stressors?_____
_____
_____

Are you having financial/legal difficulties?_____
_____
_____

What do you do to cope?_____
_____
_____

Have you had any significant losses (relatives, friends, jobs, pets, etc.)?_____
_____
_____

Military History
Branch of Service_____ Dates_____
Combat Experience_____ Dates_____
Combat Trauma_____ Dates_____
Psychiatric Inpatient/Outpatient Treatment_____ Dates_____

Veteran Support Group_____ Dates_____
Educational History

Names of Schools_____ Dates_____

_____

Highest Academic Level_____ Dates_____

Other Job Training_____ Dates_____

Job History

Current Place of Employment _____ How long?_____

Previous Employment_____ Dates_____

_____

What do you do for leisure?

_____

_____

Do you have a regular exercise program?_____

Church/Spiritual Affiliation_____

Any other information that would be helpful for your therapist?_____

_____

_____

_____ _____
Client Date

Reviewed by:

_____ _____
Therapist Date

Karen Mahan, LCSW
Transitions Equine LLC

# Financial Policy and Agreement

*Regarding Insurance and Managed Care*

Insurance benefits assignment may be accepted. If you are covered by insurance it will be billed if you provide insurance information. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. In the event that I accept assignment of benefits, I will give you credit for the amount covered by insurance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to you. Please be aware that thee cost of the services provided will become your responsibility if covered in part or not at all by your insurance company. **In addition, you are expected to pay the difference between the amount covered and amount owed each time you come for an appointment**. All co-pays and deductibles are due at the time of treatment. If you are a subscriber to a managed care policy, it is your responsibility to ensure that the first session is authorized by your insurance company. I also request that you understand the requirements of you insurance carrier and inform me of what procedures I must comply with to ensure payment. **While I may be a member of several managed care networks, it is your responsibility to ensure that I am a provider for your individual policy.**

**Monthly Statements**

All monthly statements are due in full upon receipt unless other arrangements have been made. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Missed Appointments**

Unless cancelled at least 24 hours in advance, you may be charged for missed appointments at the rate of **$50** per session. Insurance carriers will not pay for missed or canceled appointments. Please help me serve you better by keeping scheduled appointments.

**Treatment Plan**

I am responsible for informing you of a tentative treatment plan regarding your therapy. Together, you and I can modify or alter this plan as treatment continues.

**Fee Agreement**

The agreed upon fee for professional services is:

$_____ for initial session and $_____per 45-minute session.

I agree to pay a minimum of $_____toward the professional fees at each session. This includes any co-payment or deductible of which I am aware.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this policy. I also hereby authorize my insurance benefits to be paid directly to Karen Mahan, LCSW DBA Transitions Equine LLC and acknowledge that I am financially responsible for any unpaid balance.

_____

**Signature of Patient or Responsible Party** **Date**